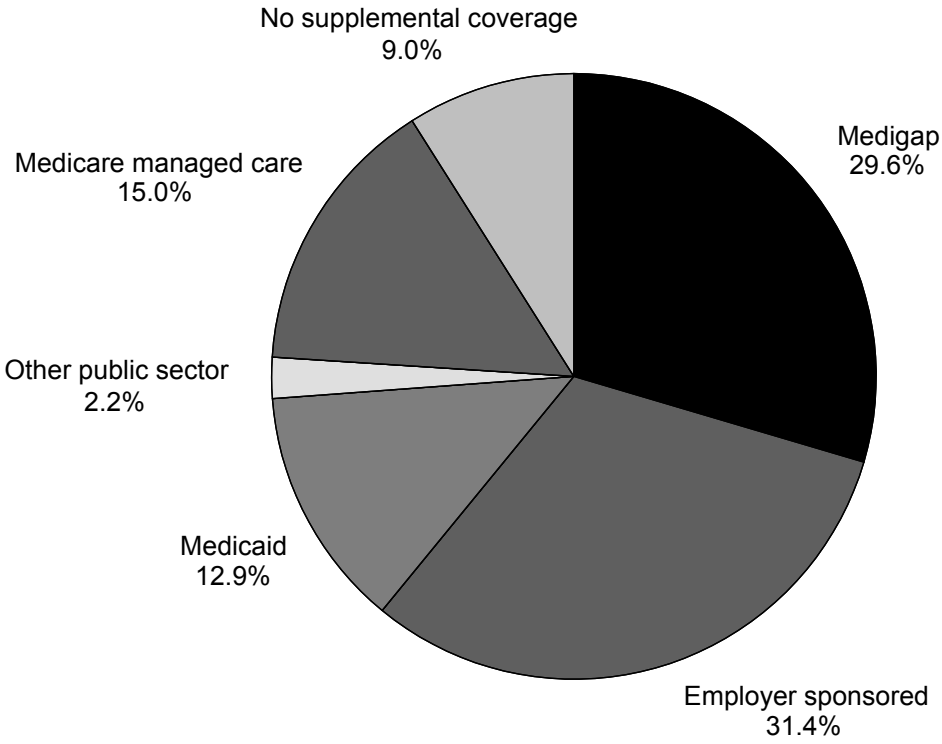
SECTION 5

Medicare beneficiary and other payer financial liability

Chart 5-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2002



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2002. They could have had coverage in other categories throughout 2002. Other public sector includes federal and state programs not included in other categories. Analysis includes only beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2002 or had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. Ninety-one percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- Sixty-one percent have Medicaid supplemental coverage such as Medigap (30 percent) or employer-sponsored retiree coverage (31 percent).
- Thirteen percent have Medicaid coverage.
- Fifteen percent participate in Medicare managed care. This includes Medicare+Choice (now Medicare Advantage), cost, and health care prepayment plans. These types of arrangements generally replace Medicare coverage and often add to it.

Chart 5-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2002

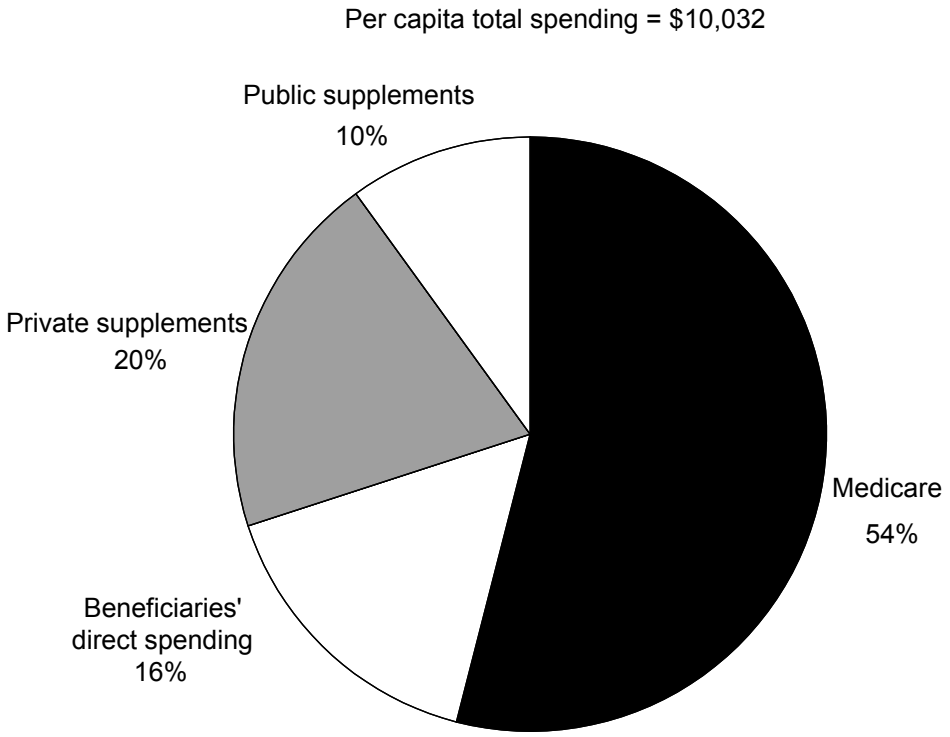
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**35,684**	**31.4%**	**29.6%**	**12.9%**	**15.0%**	**2.2%**	**9.0%**
Age							
< 65	4,499	17.2	5.7	44.7	8.5	3.6	20.2
65–69	8,039	36.8	28.1	8.7	15.3	2.1	8.9
70–74	7,791	33.9	32.5	7.1	16.4	2.3	7.7
75–79	6,889	32.7	34.3	7.9	17.2	1.5	6.4
80–84	4,882	33.0	35.9	8.9	14.5	1.7	6.1
85+	3,585	26.6	38.9	10.0	15.6	1.8	7.2
Income status							
Below poverty	5,724	9.4	16.3	51.5	9.6	1.6	11.7
100–125% of poverty	3,413	16.6	24.5	26.4	15.4	3.3	13.9
125–200% of poverty	7,327	25.9	31.3	7.7	17.9	3.8	13.4
200–400% of poverty	10,959	39.9	33.1	1.4	17.4	1.5	6.7
Over 400% of poverty	8,190	46.3	34.9	0.4	12.6	1.4	4.4
Eligibility status							
Aged	31,070	33.4	33.1	8.3	15.9	2.0	7.4
Disabled	4,346	16.6	5.7	44.4	8.8	3.7	20.7
ESRD	267	34.1	12.9	40.5	8.4	0.0	4.1
Residence							
Urban	27,138	32.5	26.5	12.1	18.8	2.1	7.9
Rural	8,513	27.7	39.5	15.1	2.7	2.2	12.8
Sex							
Male	15,723	32.9	26.2	11.8	14.6	2.4	12.0
Female	19,961	30.1	32.3	13.7	15.2	2.0	6.7
Health status							
Excellent/very good	14,633	34.4	33.5	6.3	16.4	1.6	7.8
Good/fair	17,890	29.7	28.5	15.9	14.6	2.4	8.9
Poor	2,986	26.6	16.4	27.8	10.7	2.9	15.6

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2002. They could have had coverage in other categories throughout 2002. Medicare managed care includes Medicare+Choice, cost, and health care prepayment plans. Other public sector includes federal and state programs not included in other categories. In 2002, poverty was defined as $8,628 for people living alone and as $10,885 for married couples. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes only beneficiaries living in the community. It only excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2002 or had Medicare as a second payer. In previous editions of the Data Book, this analysis included beneficiaries only in Part A or Part B and those who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- Employer-sponsored supplemental coverage is most common among those who are age 65 to 84, higher income (above 200 percent of poverty), eligible due to age or ESRD, urban dwelling, male, and who report excellent or very good health.
- Medigap is most common among those who are "older" aged (age 80 or older), middle or high income (above 125 percent of poverty), eligible due to age, rural dwelling, female, and who report excellent or very good health.
- Medicaid coverage is most common among those who are under 65, low income (below 125 percent of poverty), eligible due to disability or ESRD, rural dwelling, female, and who report poor health.
- Medicare managed care is most common among those who are age 65 or older, middle income (between 125 and 400 percent of poverty), eligible due to age, urban dwelling, and who report excellent or very good health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, with income between 100 and 200 percent of poverty, eligible due to disability, rural dwelling, male, and who report poor health.

Chart 5-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2002



Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually-purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Analysis includes only FFS beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

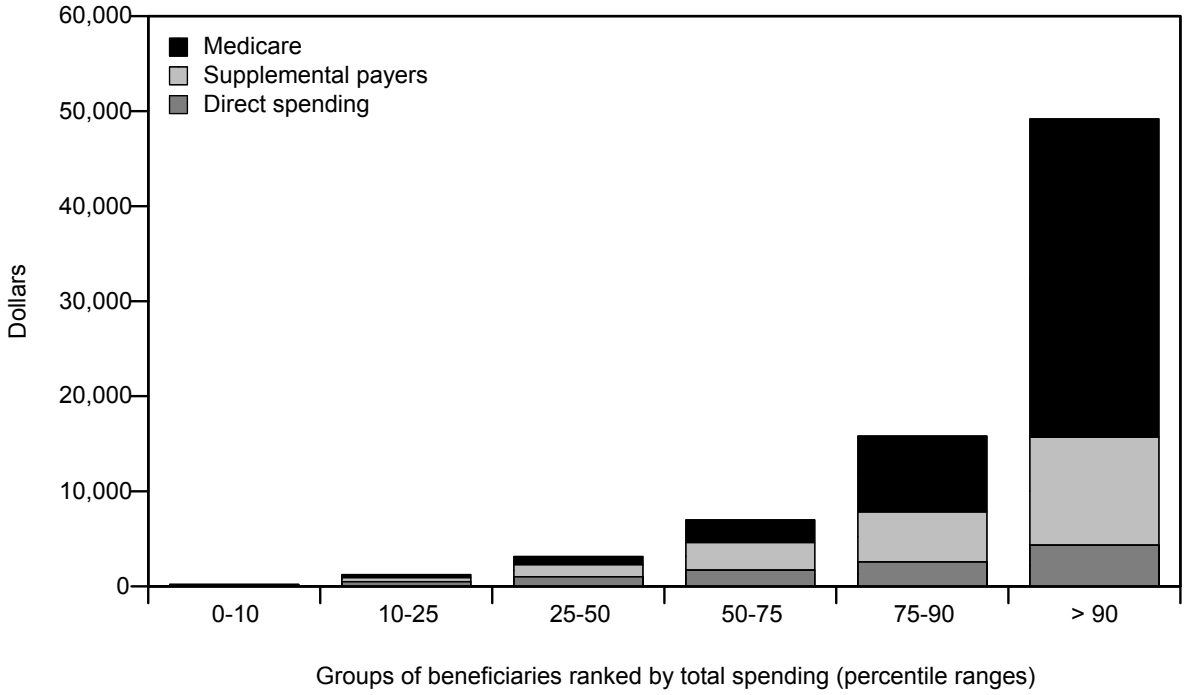
- Among fee-for-service (FFS) beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averages $10,032. Medicare is the largest source of payment; it pays 54 percent of the health care costs for FFS beneficiaries living in the community, or an average of $5,410 per beneficiary.

- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—pay 20 percent of beneficiaries' costs, or an average of $2,004 per beneficiary.

- Beneficiaries pay 16 percent of their health care costs out of pocket, with an average of $1,594 of spending per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—pay 10 percent of beneficiaries' health care costs, or an average of $1,023 per beneficiary.

Chart 5-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2002



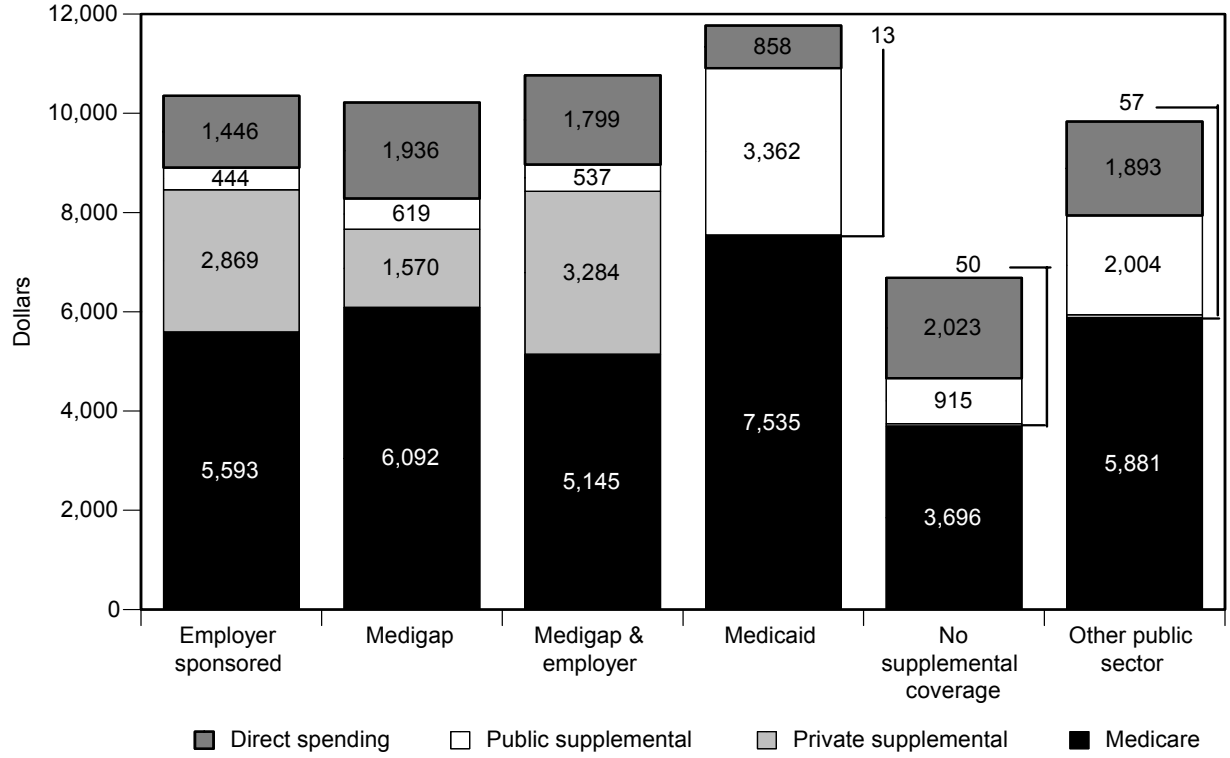
Note: FFS (fee-for-service). Analysis includes fee-for-service beneficiaries living in the community. Direct spending is on Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- Total spending on health care services varies dramatically among fee-for-service (FFS) beneficiaries living in the community. Spending for the 10 percent of beneficiaries with the highest total spending averages $49,200. Spending for the 10 percent of beneficiaries with the lowest total spending (including those with no spending) averages $208.

- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' direct spending is a smaller percentage as total spending increases. For example, Medicare pays 54 percent of total spending for all beneficiaries, but 68 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' direct spending covers 16 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 5-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2002



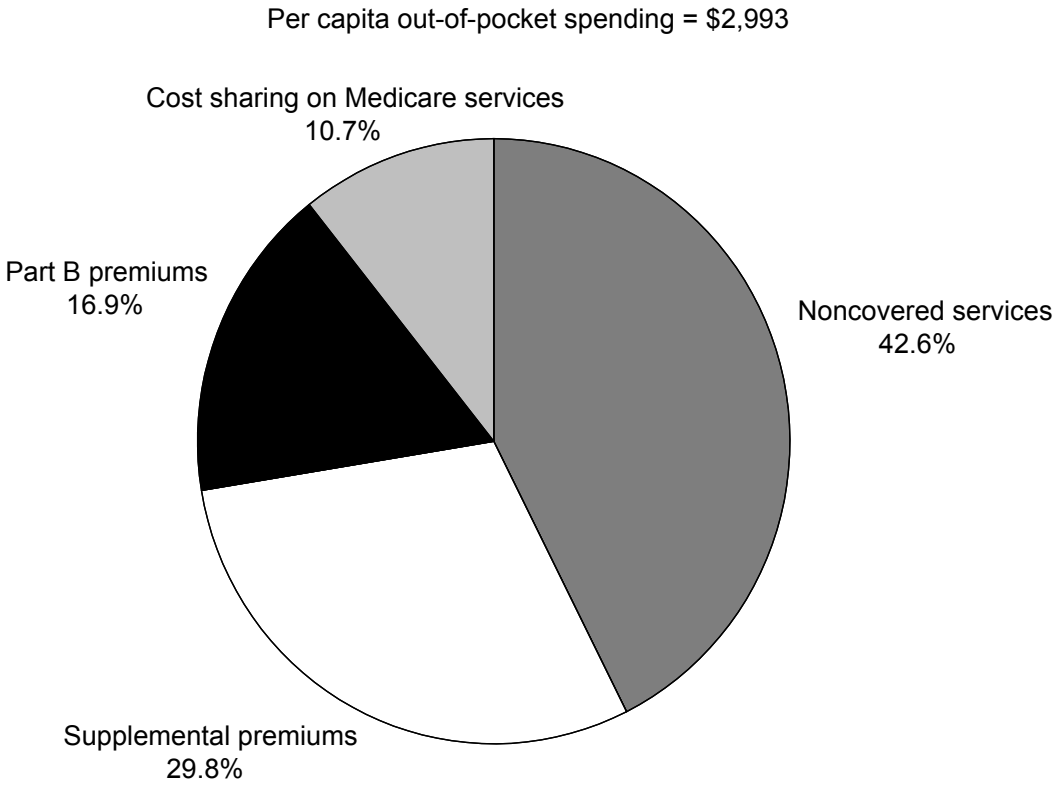
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2002. They could have had coverage in other categories throughout 2002. Other public sector includes federal and state programs not included in the other categories. Private supplements include employer-sponsored plans and individually-purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Analysis includes only FFS beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2002 or had Medicare as a second payer. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among fee-for-service beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 76 percent higher than those with no supplemental coverage.

- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with supplemental coverage, supplemental coverage is the second largest source of payment. However, among those with Medicare only, beneficiaries' direct spending is the second largest source of payment.

Chart 5-6. Types of out-of-pocket spending among noninstitutionalized FFS beneficiaries, 2002



Note: FFS (fee-for-service). Analysis includes only FFS beneficiaries living in the community.

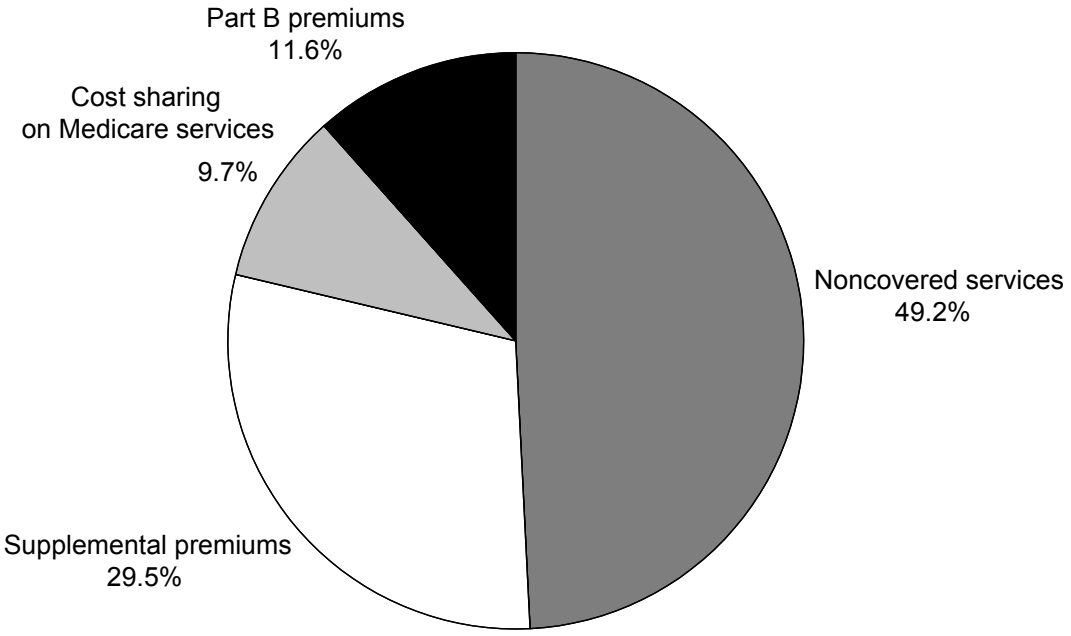
Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002

- Many beneficiaries have substantial health care liabilities that Medicare does not cover. Medicare has cost sharing on services it covers, and in the year represented by the data (2002), Medicare did not cover services such as most outpatient prescription drugs and dental care. Beginning in 2006, Medicare will have a voluntary prescription drug program.

- The cost sharing and noncovered services must be paid out of pocket by beneficiaries or through supplemental coverage. Beneficiaries often pay out of pocket for some or all premiums for supplemental coverage. Moreover, they generally pay out of pocket for the Part B premium.

- Average per capita out-of-pocket spending in 2002 was $2,993 for fee-for-service beneficiaries living in the community. Noncovered services made up the largest share—43 percent—of that amount in 2002. The share of out-of-pocket spending attributable to noncovered services will likely decline in 2006, when the voluntary drug program begins.

Chart 5-7. Sources of change in out-of-pocket spending among noninstitutionalized FFS beneficiaries, 1993–2002



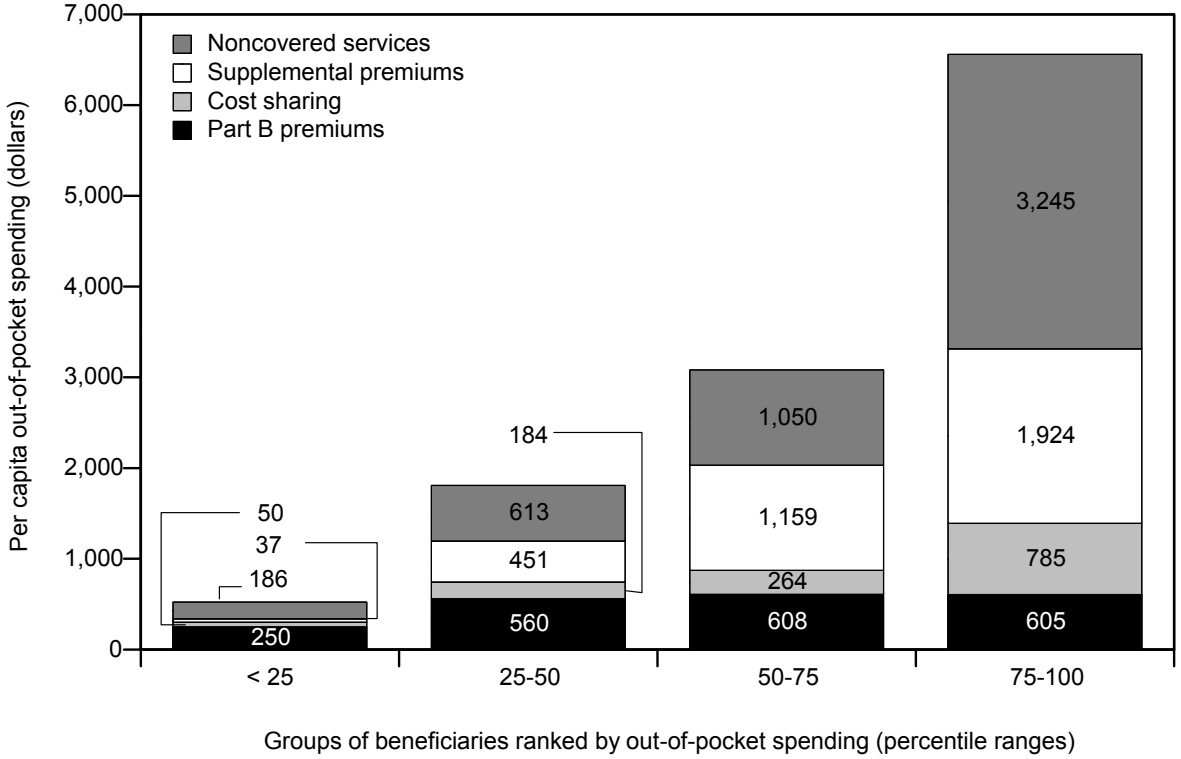
Note: FFS (fee-for-service). Analysis includes only FFS beneficiaries living in the community. Analysis does not adjust for inflation.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002

- Some components of out-of-pocket spending have contributed much more than others to overall increases in out-of-pocket spending. Among fee-for-service beneficiaries living in the community, per capita out-of-pocket spending increased from $1,784 in 1993 to $2,993 in 2002, about 5.9 percent annually. Noncovered services, such as outpatient prescription drugs, account for the largest share—49 percent—of the increase.

- Out-of-pocket spending may actually decline in 2006 when the voluntary prescription drug program begins. Moreover, the share of the growth that is attributed to noncovered services will likely decline.

Chart 5-8. Out-of-pocket spending among noninstitutionalized FFS beneficiaries, by out-of-pocket spending level, 2002



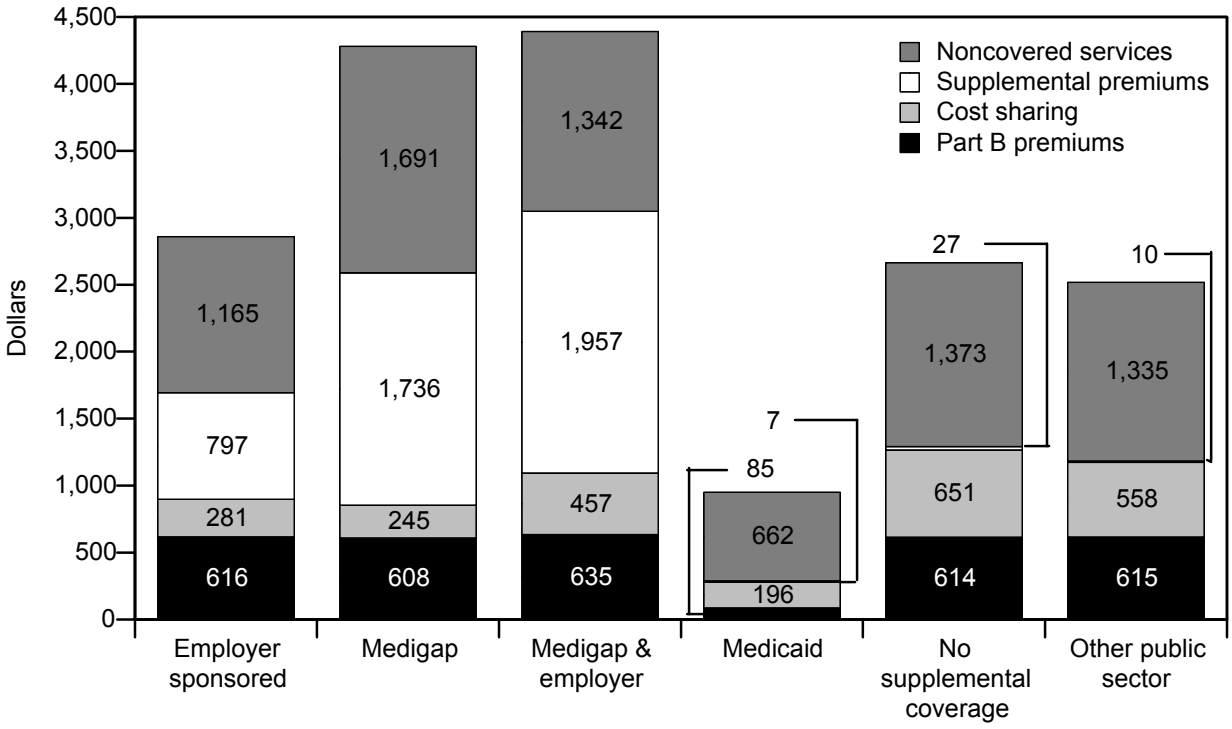
Note: FFS (fee-for-service). Sample of 9,835 includes only community-dwelling, FFS beneficiaries in 2002.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- The level of out-of-pocket spending varies widely among fee-for-service beneficiaries living in the community. The 25 percent of beneficiaries with the lowest out-of-pocket spending average $523. The 25 percent of beneficiaries with the highest out-of-pocket spending average $6,600.

- The composition of out-of-pocket spending changes as spending increases. Noncovered services and supplemental premiums tend to represent a larger share as out-of-pocket spending increases. Relative to the other categories, cost sharing maintains a more constant share as out-of-pocket spending increases. Finally, the Part B premium tends to represent a decreasing share as out-of-pocket spending increases, even though the magnitude of out-of-pocket spending on the Part B premium tends to increase. The relatively low level of out-of-pocket spending on the Part B premium in the lowest quartile ($250) reflects, in part, the fact that beneficiaries eligible for Medicaid do not pay out of pocket for the Part B premium.

Chart 5-9. Out-of-pocket spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2002



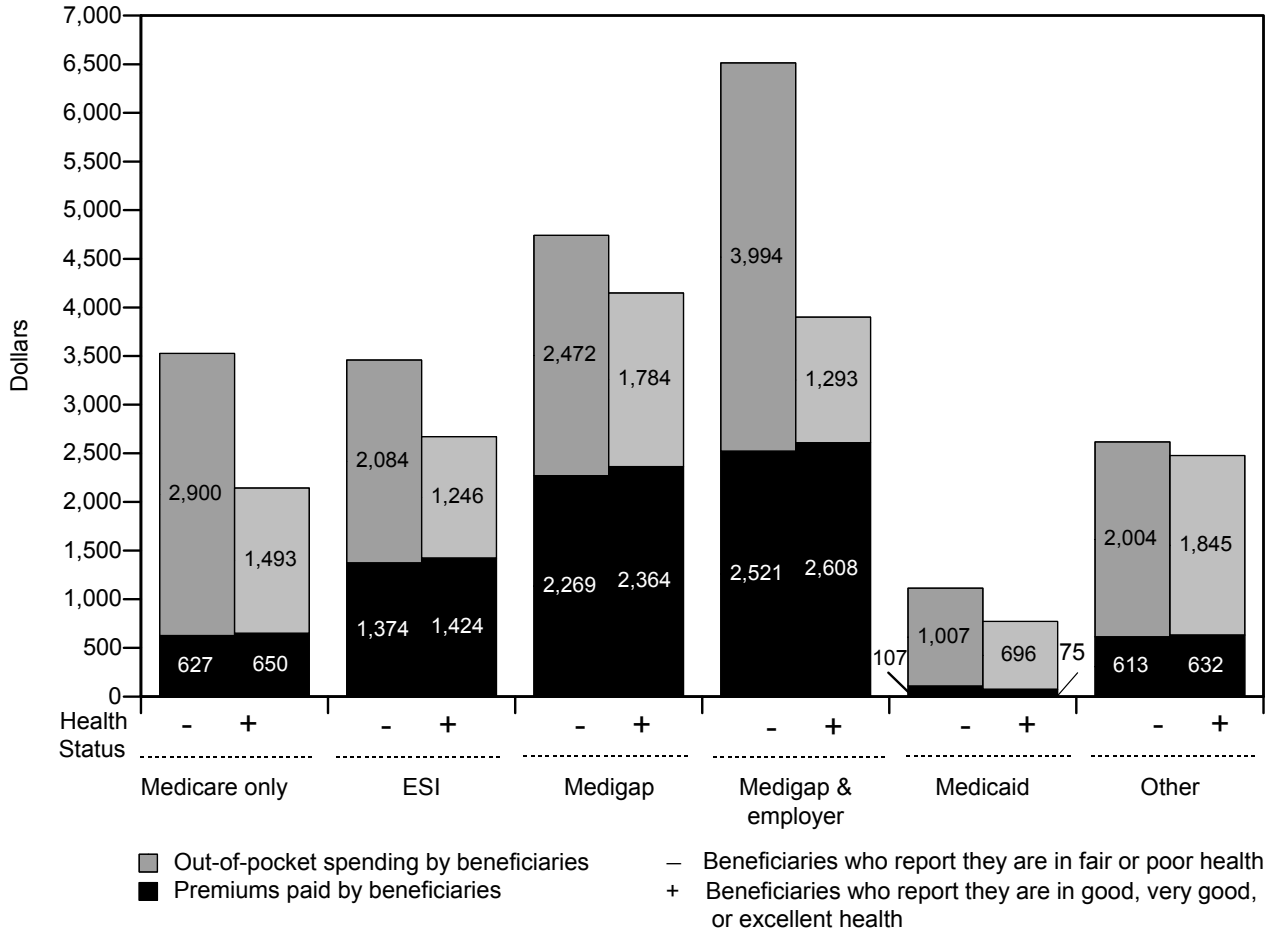
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2002. They could have had coverage in other categories throughout 2002. Other public sector includes federal and state programs not included in the other categories. Analysis includes only FFS beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2002 or had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files, 2002.

- Out-of-pocket spending varies widely by a beneficiary's type of supplemental coverage. Beneficiaries with Medicaid coverage have the lowest average out-of-pocket spending, $950. Beneficiaries with Medigap, or Medigap with employer-sponsored supplemental coverage, have the highest average out-of-pocket spending, about $4,300, of which premiums make up between 55 and 60%.

- The composition of out-of-pocket spending differs by type of supplemental coverage. Supplemental premiums are relatively high for beneficiaries with Medigap coverage, reflecting the lack of subsidy for this type of coverage. In contrast, employers often subsidize the cost of retiree health insurance. Noncovered services are the largest component of out-of-pocket spending for beneficiaries in the other categories of supplemental coverage.

Chart 5-10. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2002



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2002.

- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare.

- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with Medigap, out-of-pocket spending generally reflects the premiums and costs of prescription drugs and other services not covered by Medicare. Beneficiaries with employer-sponsored insurance (ESI) usually pay less out of pocket for prescription drugs than those with Medigap, but may pay more in Medicare deductibles and cost sharing.

Web links. Medicare beneficiary and other payer financial liability

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

  http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

  http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

- Chapter 1 of the MedPAC March 2004 Report to the Congress provides more information on beneficiary and Medicare program spending as well as information about supplemental insurance.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf

- Chapter 1 of the MedPAC March 2003 Report to the Congress provides more information on beneficiary and program spending.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch1.pdf

- Chapter 1 of the MedPAC March 2005 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/publications/congressional_reports/June 05_ch1.pdf